

GENERAL INFORMATION

Name _____ Date of Birth _____

Parents' Names _____ Child's Social Security # _____

Address _____

STREET

APT. NO.

Phone _____

CITY

STATE

ZIP

How did you here about our office? _____

Primary reason/concern for today's visit _____

MEDICAL HISTORY

Was birth full-term? _____ Weeks early/late _____ Birth Weight _____

Any complications during pregnancy or delivery? _____

Normal development? _____ Walked at what age? _____ Pediatrician _____

Current medications _____

Allergies _____

Major childhood illnesses or hospitalizations _____

ACADEMIC HISTORY

School name and address _____

Grade _____ Teacher _____ Has a grade ever been repeated? _____

Does child perform at expected levels for age in school? _____

Problem areas: Reading _____ Math _____ Spelling _____ Writing _____ Other _____

Does child enjoy school? _____ Has child had any tutoring/remedial work? _____

VISUAL HISTORY

Last complete vision exam: Doctor's name _____ Date _____

Results _____ Were glasses or contacts prescribed? _____ Are they worn? _____

Does the child complain of or do you notice: (please circle)

Blurry vision distance/near

Headaches

Eyestrain

Double vision

Letter reversals: b vs. d

Turned eye in/out constantly/sometimes

Skipping/Re-reading of lines while reading

Poor hand eye coordination

Gets very close to near work

Avoids near work

Short attention span

Word reversals: was vs. saw

